COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
COMPLIANCE PLAN

1.0 INTRODUCTION

This Compliance Plan is prepared to demonstrate the County of Los Angeles Department of Mental Health's (County's) good faith effort to make significant changes to claims and claims processing as requested by the State of California Department of Mental Health (State). This plan defines the approach, dependencies, testing and implementation schedules, and risks.

2.0 OVERVIEW OF CHANGES

The changes include the Global Unique Identifier (GUID), Net Billed Calculation, National Provider Identifier (NPI), the 1996 Health Insurance Portability and Accountability Act (HIPAA) Deny/Correct transaction, HIPAA Void/Replace transaction, discontinuation of proprietary format claims, and Explanation of Benefits (EOB) sunset.

The County recognizes that implementation of these changes is significant and complex. Although a draft companion guide was provided in January 2007, one concern of the County's with providing these estimates is that a finalized Companion Guide has not yet been published by the State. Changes to the requirements have been documented by the County as they have been presented and updated during the various teleconferences and web casts. Based on these requirements and on the draft State Companion Guide, the County is providing these estimates to the best of our ability with the information we have at hand. If additional requirements are implemented in the future during the identified timelines, the County's ability to successfully meet this implementation and testing schedule will be greatly impacted.

The County will fully expect that any delay in implementing these changes will not cause delay in payment of State claims. It is also expected that any claims that could be uploaded during these times should not be penalized as late.

2.1 DEFINITIONS/DESCRIPTION OF CHANGES

Below is the County's understanding of the required changes and explanations for the County's inability to meet the State's timelines.

2.1.1 Global Unique Identifier (GUID)

The GUID is required as a first step for the implementation of the Void, Replace and Correction function on the HIPAA compliant claims. The implementation of the Unique Identifier ensures the integrity of the VCR transactions by eliminating the potential for duplicate claims in the State's legacy system.

Based on our current testing schedule, the County believes this will be implemented by the required deadline of June 8, 2007.

2.1.2 Net Billed Calculation

The State's first implementation of the calculation for the HIPAA compliant claim "Line Item Charge Amount" mirrored the State's legacy processing system configuration for this amount, which is the "Net Billed Amount" (customary charge less other payments). HIPAA requires the gross amount to be placed in the line item amount field. In an April letter, the State announced that this amount should now be submitted according to HIPAA guidelines.

Please note that when the County first implemented their HIPAA compliant 837 in 2003, the County formatted its 837 "Line Item Charge Amount" with the gross amount, according to HIPAA requirements. At that time, the County was requested by the State to remove this programming logic and change it to net billing. Now that this requirement is being reversed, this change has resulted in additional vendor changes for the County. All internal calculations on payments submitted will need to be analyzed, for directly operated, inpatient, residential, contract provider and FFS providers.

In addition to the steps required for modifying all system logic to ensure the correct gross and other payment amounts are forwarded on the outbound claims to the State, the County also needs to modify business rules for inbound claims. The County will need to notify all contract and FFS providers to modify inbound claims to include the gross amount and other payment amounts appropriately. This will require a testing and certification effort with providers for inbound claims.

Since the County's understanding of HIPAA indicates that previous payment amounts can be reported in more than one area, the County is waiting for the finalized Companion Guide to obtain clear direction regarding the State's requirements for reporting the gross and previous payment amounts.

2.1.3 National Provider Identifier (NPI)

HIPAA required that each healthcare provider be issued a unique, national provider identifier (NPI). All HIPAA compliant claims for payment must contain an NPI for providers whether they are individuals or organizations. CMS has indicated that although the Federal implementation date is May 23, 2007, CMS will not enforce nor fine non-compliant entities, given the readiness of the nation, until May 23, 2008. However, for those entities who have not implemented NPIs

as of May 23, 2007, they must be able to demonstrate good faith by having applied for and collected the needed NPIs and must have a contingency plan on how they plan to meet the May 23, 2007 implementation date. The State deadline for implementing the NPI changes for HIPAA compliant claims was May 23, 2007.

In regard to NPI, CMS is the agency responsible for ensuring the implementation of the NPI. CMS has indicated that although the Federal implementation date is May 23, 2007, CMS will not enforce nor fine non-compliant entities, given the readiness of the nation, until May 23, 2008. However, for those entities who have not implemented NPIs as of May 23, 2008, they must be able to demonstrate good faith by having applied for and collected the needed NPIs and must have a contingency plan on how they plan to meet the May 23, 2008 implementation date.

First, the County submitted a list of issues/questions to Vonnie Ryser, Chief of the State Office of HIPAA Compliance, regarding NPI mapping for outbound claims. In addition, in various meetings, the State has indicated that there have been significant changes to the requirements for NPI. Due to the outstanding issues and pending changes, the County is waiting for the finalized Companion Guide in order to obtain the clear direction regarding the State's requirements and updates for reporting the NPI number.

Second, the County receives approximately one half of a million claims each month from contract and Fee-for-Service (FFS) providers. In addition to coding outbound claims, the NPI changes also affect the receipt of provider claims by the County. The County needs to publish correct and complete information for these contract and FFS providers to include NPI numbers on claims submitted to the County. In addition to the instructional information, the County conducts its own internal claims testing and certification procedures with these providers. Without definitive requirements from the State, the County cannot definitively inform these providers how to map this information.

2.1.4 Deny/Correct

The State is paving the way for Counties to use HIPAA compliant 837 transactions to:

- Correct previously denied claims.
- Eliminate the suspended claims process.

Significant changes to receipt of claims by the County submitted from directly operated, contract and FFS providers via Electronic Data Interchange (EDI) and user interface are needed in order to implement this change. In addition, a major modification to the County's legacy application for processing FFS provider claims needs to take place. Accomplishing these changes requires significant coordination and synchronization.

The County is reluctant to implement the deny/correct transaction. A significant State requirement change to implementing deny correct is the change in location on the claims for placing the unique identifier. This requirement change was announced during a State web cast.

As with the other changes, the County is waiting for the finalized Companion Guide to obtain definitive direction regarding the State's requirements for implementing the deny/correct transaction. However, with verbal assurance from the State that this section of the Companion Guide has not been modified significantly from the draft version, the County will begin steps towards implementing the deny/correct transaction.

Even though the County will move forward with implementing this change for claims submitted to the State, as with implementing NPI, the County needs to publish correct and complete information for contract and FFS providers to transmit correction transactions to the County. It is very important for the County to receive finalized requirements from the State in order to provide this information and resource.

2.1.5 Void/Replace Transaction (VCR)

The State is paving the way for Counties to use HIPAA compliant 837 transactions to:

- Void and replace invalid approved claims.
- Eliminate the suspended claims process.

Significant changes to receipt of claims by the County from directly operated, contract and FFS providers via EDI and user interface are needed in order to implement this change. In addition, a major modification to the County's legacy application for processing FFS provider claims needs to take place. Accomplishing these changes requires significant coordination and synchronization. Again, with these changes involving intricate details and timing, the County is waiting for the finalized Companion Guide to obtain clear direction regarding the State's requirements in order to avoid modifying changes that are implemented incorrectly.

The County will implement the void/replace transaction after successful implementation of the deny/correct transaction and delivery of a Final Companion Guide.

2.1.6 Discontinuation of "Proprietary Claim" Format

The State announced that proprietary format claims would no longer be accepted from counties effective June 30, 2007. The County requests the State to continue accepting its proprietary claims after the June 30, 2007 cutoff.

The County is currently submitting non-HIPAA compliant, proprietary format claims to the State in two instances. First, the County submits corrections to claims identified on the Error Correct Report (ECR) for FFS provider claims in proprietary format claim transactions. Second, the County also submits out-of-County foster care claims to the State in proprietary format claim transactions.

In the first instance, the County will discontinue transmitting FFS ECR proprietary claims to the State immediately after implementing the deny/correct transaction.

In the second instance, the County's vendor, Value Options, is currently in the process of converting the foster care claims from the proprietary format to the HIPAA compliant format. The State in a recent conference call announced a possible new requirement for foster care claims. No further information has been provided and we are currently working from a DRAFT Companion Guide that we have been told by the State that it is no longer accurate. This development effort is on hold until a Final State Companion Guide is provided.

2.1.7 EOB Sunset

The State announced that Explanation of Benefits (EOB) would no longer be distributed to counties effective June 30, 2007. The County requests the State to continue sending the State EOB after the June 30, 2007 cutoff.

The EOB is needed to process corrections for all County claims (directly operated, contract provider and FFS provider claims) until both the Deny/Correct and Void/Replace transactions are successfully implemented with the State.

In addition, the EOB is needed for remittance advice information until the County's foster care claims are transmitted in HIPAA compliant 837 claim transactions and the County's vendor is able to process the State's HIPAA compliant 835 remittance advice transaction.

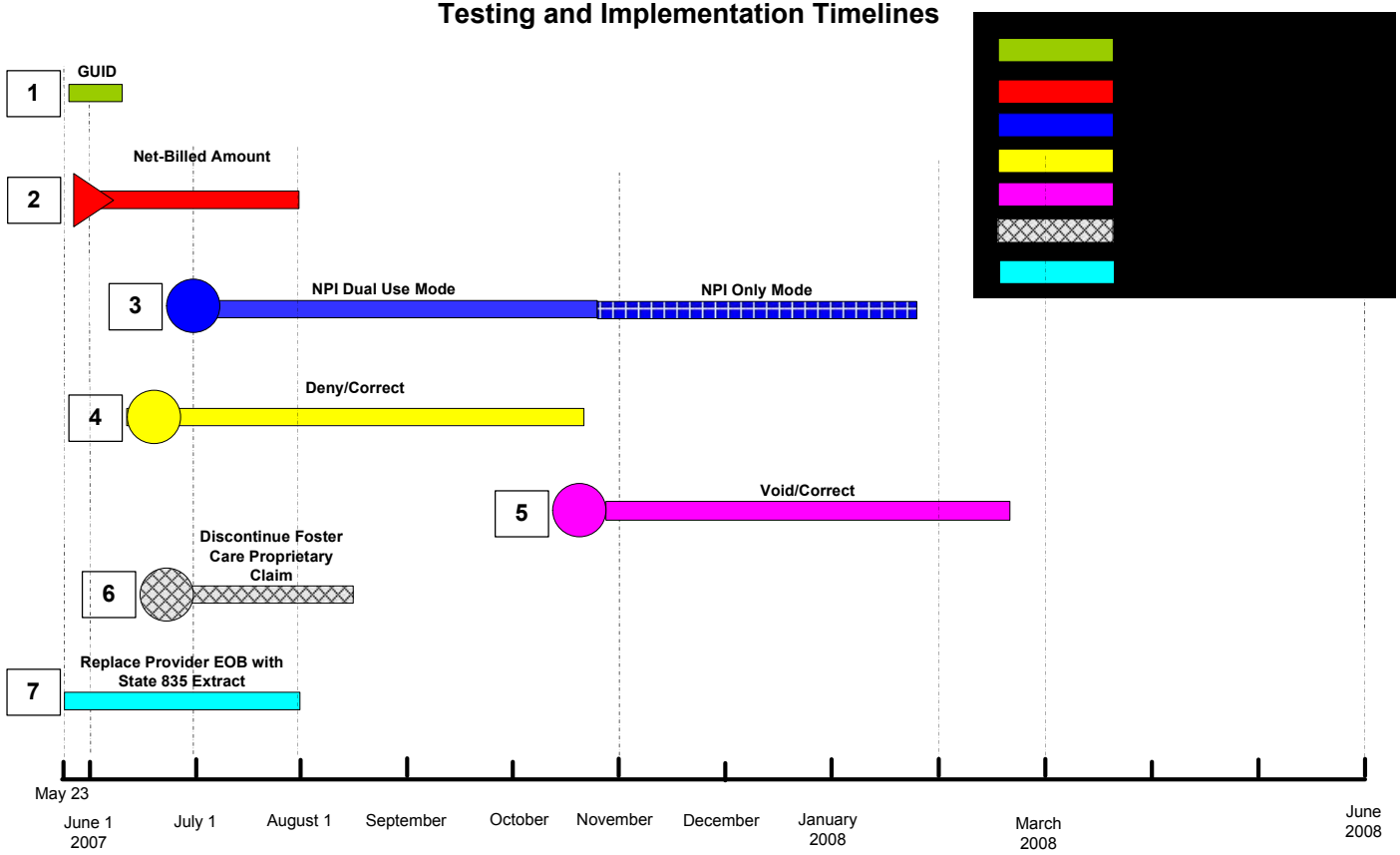
Finally, the EOB is required for reporting purposes for the County's contract providers. The County is currently developing a process to receive the State 835, parse critical 835 data by contract provider legal entity, and distribute the parsed 835s to providers in a database format. The County plans to have this process implemented by early August.

3.0 TESTING AND IMPLEMENTATION SCHEDULE

The planned order of implementation is according to the order of the changes in the table. To note, changes are dependent on the receipt of a finalized State Companion Guide.

	CLAIMS PROCESSING CHANGE	CODING START DATE	COUNTY TESTING AND CERTIFICATION TIMELINE	COUNTY PRODUCTION COMPLIANCE TIMELINE	DEPENDENCY
1	Global Unique Identifier (GUID)				In progress
2	Net-Billed Amount	Submission of compliance plan	2 months	August, 2007	1
3	National Provider Identifier	Receipt of final Companion Guide and during test phase Change 2			1, 2 State Final Companion Guide
	Dual use		4-5 months	October 2007	
	NPI only	2-3 months prior to State NPI only cutoff	3 months	February 2008	
4	Deny/Correct	During testing of Change 2	4 months	October 2007	1, 2
5	Void/Replace	Receipt of final Companion Guide	4 months	February 2008	1, 2, 3, 4 State Final Companion Guide
6	Discontinue Proprietary Claim Format				
	FFS Proprietary Claims		N/A	February 2008	4, 5
	Foster Care Proprietary Claims	Receipt of final Companion Guide	July 2007	Early August 2007	State Final Companion Guide
7	EOB Sunset				
	Discontinue ECR		N/A	October 2007	4
	Replace EOB with 835		July 2007	August 2007	In progress

Los Angeles County Department of Mental Health
Testing and Implementation Timelines



NPI – National Provider Identifier
EOB – Explanation of Balances File
ECR – Error Correction Report

4.0 LIST OF TASKS FOR EACH CHANGE

4.1 GUID Requirement

This change was implemented utilizing the State's draft Companion Guide and information disseminated at various web casts. The programming is based on the County's understanding of the requirements.

Task	Dependencies	Status
4.1.1 Add the logic for GUID in all outbound claim types in vendor test environment		Completed
4.1.2 Test GUID changes with State		In progress
4.1.3 Obtain State certification	Completion of 4.1.2	
4.1.4 Implement change to production	Completion of 4.1.3	

4.2 Net Billed Amount Calculation

Task	Dependencies	Status
4.2.1 Obtain clarification of mapping	State Finalized Companion Guide	
4.2.2 Obtain clarification of formulas for cost amounts	State Finalized Companion Guide	
4.2.3 Prepare requirements for EDI and user interface changes	Completion of 4.2.1 and 4.2.2.	
4.2.4 Add logic for all claim types	Completion of 4.2.3.	
4.2.5 Test changes internally	Completion of 4.2.4	
4.2.6 Tests changes with State	Completion of 4.2.5	
4.2.7 Obtain State certification	Completion of 4.2.6	
4.2.8 Implement change to production	Completion of 4.2.7	

4.3 National Provider Identifier (NPI)

Task	Dependencies	Status
4.3.1 Gather Numbers		
4.3.1.1 Send notification to contract providers requesting NPI numbers.		Completed
4.3.1.2 Apply for NPI for directly operated organizational providers.	Registering new provider numbers with Medi-Cal oversight and certification	100% complete
4.3.1.3 Collect NPI for directly operated	100% outstanding	99% complete

4.3 National Provider Identifier (NPI)		
Task	Dependencies	Status
rendering providers	are return to work issues.	
4.3.1.4 Collect organizational NPI numbers from contract providers and FFS providers		In progress
4.3.1.5 Collect rendering NPI numbers from contract and FFS providers		In progress
4.3.1.6 Upload NPI numbers to County system		In progress
4.3.1.7 Add new taxonomies to County system		
4.3.2 Build County Crosswalk		In progress
4.3.3 Build State Crosswalk		In progress
4.3.3.1 Submitted requirements to vendor to load NPI numbers.		Completed
4.3.3.2 Resolve Satellite and School Based NPI designations.		Completed
4.3.4.1 Send Master list to State for discrepancy resolution – directly operated		In progress
4.3.4.2 Send Master list to State for discrepancy resolution – contract providers		In progress
4.3.4.3 Send Master list to State for discrepancy resolution – FFS Outpatient providers		
4.3.4.4 Map NPIs with legacy identifiers		
4.3.4 Obtain clarification of mapping from State	State Finalized Companion Guide	
4.3.5 Define business requirements	Dependent on 4.3.4	
4.3.6 Modify inbound claims logic for dual use mode.	Dependent on 4.3.5.	
4.3.7 Modify outbound claims logic for dual use mode for all claim types		
4.3.8 Test dual use mode internally		
4.3.9 Test dual use mode with State		
4.3.10 Obtain State certification for dual use		
4.3.11 Implement dual use mode in production		
4.3.12 Modify outbound claims NPI only mode	Dependent on 4.3.5.	
4.3.13 Test NPI only mode internally		
4.3.14 Test NPI only mode with State		
4.3.15 Obtain State certification for NPI only		
4.3.16 Implement NPI only in production		

4.4 Deny/Correct Transaction This change will be implemented utilizing the State's draft Companion Guide and information disseminated at various web casts. The programming will be based on the County's understanding of the requirements.		
Task	Dependencies	Status
4.4.1 Obtain State clarification of mapping	State Finalized Companion Guide	
4.4.2 Prepare requirements for EDI, user interface and FFS legacy system changes	Completion of 4.4.1	
4.4.3 Add logic for all claim types	Completion of 4.4.2	
4.4.4 Test changes internally	Completion of 4.4.3	
4.4.5 Tests changes with State	Completion of 4.4.4	
4.4.6 Obtain State certification for	Completion of 4.4.5	
4.4.7 Implement change to production	Completion of 4.4.6	

4.5 Void/Replace Transaction This change will be implemented directly following deny/correct implementation.		
Task	Dependencies	Status
4.5.1 Obtain State clarification of mapping	State Finalized Companion Guide and implementation of Deny/Correct	
4.5.2 Prepare requirements for EDI, user interface and FFS legacy system changes	Completion of 4.5.1	
FFS Outpatient Define IS to legacy mapping , requirements – Legacy system changes,		
4.5.3 Add logic for all claim types	Completion of 4.5.2	
4.5.4 Test changes internally	Completion of 4.5.3	
4.5.5 Tests changes with State	Completion of 4.5.4	
4.5.6 Obtain State certification for	Completion of 4.5.5	
4.5.7 Implement change to production	Completion of 4.5.6	

4.6 Discontinuation of "Proprietary Claim" Format		
Task	Dependencies	Status
4.6.1 Discontinue non-proprietary foster care claims	State Finalized Companion Guide	
4.6.1.1 Develop HIPAA compliant claim		
4.6.1.2 Test with State		
4.6.1.3 Obtain State certification		
4.6.1.4 Implement to production		
4.6.2 Discontinue FFS DECR/ECR non-proprietary format	Continue until Deny/Correct and Void/Replace transactions are implemented	

4.7 EOB Shutdown		
Task	Dependencies	Status
Implement Deny/Correct	See table 4.4	
Implement Void/Replace	See table 4.5	
Implement provider 835 data extracts		In progress

5.0 RISKS

The following sections identify risks known to date that may impact the County's timelines and/or ability to successfully implement these changes. In the midst of these changes, the County must balance compliance with business continuity.

In discussing risks, the most critical factor impacting the County is the unavailability of a finalized State Companion Guide that outlines the specifications for the requested changes. The County is currently utilizing the State's draft Companion Guide that was distributed earlier this year. The State continues to assert that there have been extensive changes to the draft. Therefore, there is risk that the County will implement changes that need to be modified at a later date once the finalized Companion Guide is released.

The County's approach is to implement each change in succession, in other words, only after successful certification of the previous change has been obtained. In addition, all but one of the changes includes modifying County business and system processing of inbound claims. The risk being faced by the County is tight deadlines for analysis, provider notification, internal testing, and provider certification.

Other risks include County and vendor personnel changes, staff retention, new and changing State requirements, implementation of other County IT projects, and State turnaround times for response transactions of test claims.

6.0 CONTACTS

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